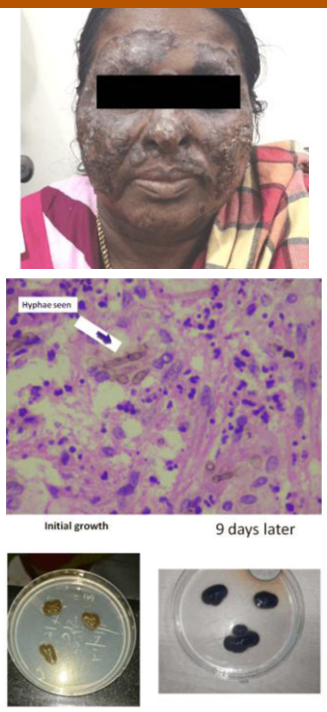

Results: Clinical diagnosis included disseminated chromoblastomycosis with chronic osteomyelitis. She underwent extensive debridement of lesions of both legs and tissue/pus sent for cultures. Biopsy revealed granulomatous infiltration composed of neutrophils and multinucleated giant cells. H&E and PAS staining showed pigmented septate hyphae proliferating in and around granulomas and budding yeast form of fungus (Fig. 2). Isolate was sent for definitive identification, susceptibility testing and molecular typing to the Center of Advance Research in Medical Mycology, PGI, Chandigarh. Incubation on Sabouraud's glucose agar medium yielded grey-black and yeast-like colonies in which the hyphae were morphologically expanding with the formation of annelloconidia (Fig.3), indicating that the isolate was an *Exophiala* species.. The patient was started on oral itraconazole and terbinafine. An improvement was observed 2 weeks after commencement of treatment, leading to gradual, but dramatic, resolution of the lesions.

Conclusion: This case highlights various manifestation of E spinifera presenting clinically as chromoblastomycosis & histopathologically as phaeohyphomycosis in an immunocompetent adult with excellent response to itraconazole and possibly lower sensitivity to voriconazole.

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Clinical diversity in central nervous system cryptococcosis

J.M. Koshy[1,*], S. Mohan[1], D. Deodhar[1], M. John[2], A. Oberoi[1]

[1] *Christian Medical College, Ludhiana, Ludhiana, India*
[2] *Christian Medical College, Ludhiana, India*

Background: Though cryptococcal meningitis (CM) is recognized as a disease of the immunocompromised, studies have implicated that it also affect immunocompetent patients.

Methods & Materials: This was a cross sectional study conducted in the Department of Medicine ofa tertiary teaching institution in North India. All the patients diagnosed with cryptococcal meningitis on the basis of detection of cryptococcal antigen or the presence of capsulated budding yeast cells on India ink preparation,from April 2009 to March2015 were included in the study. Demographical profile, clinical presentation, predisposing factors, CSFcharacteristics, imaging abnormalities and in patient outcome were noted and analyzed

Results: Among the 40 patients diagnosed with CM, 62.5% of them were males. Eight patients were immunocompetent, 10 had predisposing factors other than HIV and 22 had HIV infection (initial presentation in 59%). Mean age of presentation was 44.75 +/_ 15.78 years. Mean duration of symptoms in all three groups varied from 3-4 weeks.

Clinical presentations included fever (16), headache (14), altered sensorium (16), seizures (5), paraparesis (4), hemiparesis (2), lateral rectus palsy (3), VII nerve palsy (2), bilateral vision loss with ptosis (1) and ataxia (1). Neck stiffness was present in 50% patients of immunocompetent group, 45.45% of HIV patients and none in the 3rd group.

Acellular CSF (37.5%) was not unusual. Mean CSF white cell count in HIV patients, in other immunocompromised patients and immunocompetent patients were 159.09 +/_ 317.42, 36.88 +/_92.43 and 32.5 +/_62.05 /mm^3 respectively which was predominantly lymphocytic. Mean CSF protein were 136.73 +/_ 139.82, 62.67 +/_ 51.11 and 152.29 +/_ 218.24 g/dl in these groups. Abnormalities detected on imaging included, meningeal enhancement, encephalomalacia, infarct, cerebellitis, hydrocephalus, cord hyper intensitiesand cervical spine intramedullary lesion.

Mortality rate in crytpococcal meningitis patients was 20%. On mortality analysis, death was mostly attributed to the primary disease.

Conclusion: Clinical presentation of CM in both immunocompetent and immunocompromised patients was similar. Though previous studies noted less inflammation in immunocompromised patients, in this series HIV patients had a better inflammatory response in terms of CSF pleocytosis compared to other groups. Since the presentation of CM is variable, all cases of meningitis should be screened for the same.

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